

**ANNUAL HEALTH QUESTIONNAIRE
2007-2008**

STUDENT NAME _____ GRADE _____

ADDRESS _____ PHONE# _____

1. Does your child have any medical conditions we should know about? If yes, please list.

2. Please list any illness, injury or surgery your child had during the last year.

3. Does your child have any one of the following conditions? If yes, please specify.

Food Allergies	___ NO	___ YES	_____
Bee Sting Reaction	___ NO	___ YES	_____
Asthma Condition	___ NO	___ YES	_____
Other Allergies	___ NO	___ YES	_____

4. Please list any medications your child takes daily.

5. Does your child wear glasses? _____ NO _____ YES
Does your child wear contact lens? _____ NO _____ YES
When should your child wear the glasses/lens? _____

6. Does your child have any hearing difficulties? _____ NO _____ YES
If yes, any classroom needs? _____

7. May we share this information with the appropriate teachers? _____ NO _____ YES

8. Does your family have health insurance? _____ NO _____ YES
If no, are you interested in the Husky program? _____ NO _____ YES

9. Do you have any concerns about your child's health (eating, sleeping, and weight)?

10. Additional comments: (include any other problems that you feel the school nurse should know).

Parent Signature _____ Date _____
(please return this form to the school nurse)